INITIAL APPLICATION FOR CLINICAL PRIVILEGES

For use of this form, see AR 40-68; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 5, United States Code (USC), Sections 301; Title 44, USC, Section 3101; and Title 10,USC, Section 1071.

Principal Purpose To define the extent and limits of the practitioner's clinical privileges as a function of his or her training and experience.

Routine Uses: Determine and assess capability of practitioner's clinical practice. A copy of this form will be retained in your credentials file. Information may be provided to certain civilian hospitals, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulating bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may result in the limitation or termination of your clinical privileges.

SECTION A - IDENTIFICATION

1. NAME *(Last, first, middle)*		2. SOCIAL SECURITY NO. *(SSN)*	3. GRADE
4. CORPS	5. DATE OF ASSIGNMENT *(Day, Mo., Yr.)*	6. ASSIGNMENT LOCATION	

SECTION B - PROFESSIONAL EDUCATION

7. NAME OF PROFESSIONAL SCHOOL	8. LOCATION	9. YRS. ATTENDED		10. TYPE DEGREE	11. DEGREE COMPLETED *(Day, Mo., Yr.)*
		FROM	TO		

SECTION C - POSTGRADUATE TRAINING

12. NAME OF HOSPITAL OR INSTITUTION	13. LOCATION	14. TYPE PROGRAM *(Residency, etc.)*	15. DURATION	16. DATE COMPLETED *(Day, Mo., Yr.)*

SECTION D - PREVIOUS HOSPITAL ASSIGNMENTS

17. NAME OF HOSPITAL	18. LOCATION	19. CLINICAL SERVICE/DEPT. ASSIGNED	20. INCLUSIVE DATES *(Day, Mo., Yr.)*	
			FROM	TO

SECTION E - CERTIFICATION/PROFESSIONAL SOCIETY MEMBERSHIP

21. BOARD ELIGIBLE FROM *(Date)*	22a. BOARD EXAM TAKEN *(Date)*	22b. CHECK ☐ Total ☐ Partial	24. MEMBERSHIP IN SPECIALTY SOCIETIES *(Specify)*
23. BOARD CERTIFIED? *(If yes, give name of Board(s).* ☐ Yes ☐ No			

SECTION F - CREDENTIALS ACTION HISTORY *(If "yes" to any of the following, give full details on a separate sheet.)*

		YES	NO			YES	NO
25.	Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, or voluntarily surrendered?			28.	Have your privileges at any institution ever been limited, restricted or revoked?		
26.	Have you ever refused membership in a hospital medical staff?			29.	Has your narcotics registration ever been suspended or revoked?		
27.	Has your request for any specific clinical privileges ever been denied or granted with stated limitations?			30.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?		

SECTION G - CLINICAL PRIVILEGES APPLIED FOR

31. LIST THE APPROPRIATE DA FORM 5440-R-SERIES AND ATTACH TO THIS FORM

32a. DEA NO. *(If any)*	32b. DATE	33a. STATE LICENSURE *(If any)*	33b. DATE	33c. EXPIRATION DATE
The information contained herein is true to the best of my knowledge and belief.		34a. SIGNATURE OF APPLICANT		34b. DATE

35. Recommendations

a. PROVISIONAL STATUS	FROM	TO	b. CLINICAL PRIVILEGES
			☐ Granted as Requested. ☐ Modified *(Specify in item 28c.)*

c. MODIFICATIONS

36. Reviewed By		d. CREDENTIALS COMMITTEE *(Signature)*	e. DATE
a. DEPARTMENT/SERVICE	b. DATE	**37. Approved By**	
c. SIGNATURE		a. HOSPITAL/DENTAC COMMANDER *(Signature)*	b. DATE

38. Appointment Status

a. CLINICAL PRIVILEGES

☐ Granted as Requested. ☐ Modified *(Specify in item 38b.)*

b. MODIFICATIONS

39. Reviewed By		d. CREDENTIALS COMMITTEE *(Signature)*	e. DATE
d. DEPARTMENT/SERVICE	e. DATE	**40. Approved By**	
c. SIGNATURE		a. HOSPITAL/DENTAC COMMANDER *(Signature)*	b. DATE